CHAPTER 14

Mandated report: Dual-eligible special needs plans

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Chapter summary

Individuals who qualify for both Medicare and Medicaid—known as dual-eligible beneficiaries, or "dual eligibles"—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are particular variations of the dual-eligible special needs plan (D–SNP), which is a specialized Medicare Advantage (MA) plan. This report is our second under the BBA of 2018 mandate.

As required by the mandate, we compared plans' performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey. (We used HEDIS data in our first mandated report, while our analysis of CAHPS data is new.) We find that these data sources provide limited insight into the relative performance of D–SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. MA plans perform better on some measures

In this chapter

than Medicare-Medicaid Plans (MMPs), which are demonstration plans that operate outside the MA program, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our first mandated report and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

The landscape of health plans that serve dual eligibles will change in 2025, when the MMP demonstration is scheduled to end. Most evaluations have found that MMPs increase Medicare spending and have had mixed effects on service use. After the demonstration ends, we expect most MMPs to convert into D–SNPs. ■

Introduction

Individuals who qualify for both Medicare and Medicaid—known as dual-eligible beneficiaries, or "dual eligibles"—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. Many observers argue that managed care plans that provide both Medicare and Medicaid services would improve quality and potentially reduce spending for this population because integrated plans would have stronger incentives to coordinate care than either program has when acting on its own.

The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are particular variations of the dual-eligible special needs plan (D–SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dual eligibles.

The BBA of 2018 requires the Commission to provide a report every two years, starting in 2022 and continuing through 2032. After that, the schedule changes, with another report due in 2033 and updates required every five years. This chapter is our second report under the mandate, which we are required to submit to the Congress by March 15, 2024.

Background

Individuals must separately qualify for both Medicare and Medicaid coverage to become dual-eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. The federal-state Medicaid program covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. Medicare is the primary payer for any services that are covered by both programs, such as inpatient care and physician services.

Roughly half of dual-eligible beneficiaries first qualify for Medicare based on disability (compared with 15 percent of beneficiaries who are not dual eligibles) and roughly half qualify when they turn 65. Medicaid's eligibility rules vary somewhat across states, but most dual eligibles qualify because they receive Supplemental Security Income benefits, need nursing home care or have other high medical expenses, or meet the eligibility criteria for the Medicare Savings Programs, in which Medicaid provides assistance with Medicare premiums and cost sharing (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024). Not all individuals who are eligible for Medicaid participate in the program. In July 2022, about 12.2 million Medicare beneficiaries (19 percent of all Medicare beneficiaries) were dual eligibles.

Dual-eligible beneficiaries belong to one of two broad groups—"full benefit" and "partial benefit"—based on the Medicaid benefits they receive. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, with cost sharing.[1] In July 2022, there were 8.9 million full-benefit dual eligibles and 3.4 million partial-benefit dual eligibles.

Given the role that factors such as disability and functional impairment play in becoming a dual-eligible beneficiary, it is not surprising that dual eligibles are more likely than other Medicare beneficiaries to report that they are in poor health (11 percent vs. 4 percent) or need help performing three or more activities of daily living (ADLs) (24 percent vs. 6 percent) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024).[2] The poorer health of this population leads in turn to higher program costs (Table 14-1, p. 470). Measured on a per capita basis, the average annual Medicare cost for dual eligibles in 2021 was over $24,000, more than two times higher than the corresponding figure for other Medicare beneficiaries. Within the dual-eligible population, those eligible for full Medicaid benefits had higher Medicare costs and much higher Medicaid costs than those eligible for partial Medicaid benefits only. In 2021, Medicare and Medicaid together spent more than $44,000 per capita, on average, on full-benefit

TABLE 14–1

Dual eligibles had much higher per capita annual spending in 2021 than other Medicare beneficiaries

	Medicare	Medicaid	Total
Dual-eligible beneficiaries			
All dual eligibles	$24,370	$14,175	$38,545
Full-benefit dual eligibles	25,582	19,119	44,701
Partial-benefit dual eligibles	21,094	813	21,908
All other Medicare beneficiaries	11,172	N/A	11,172

Note: N/A (not applicable). Figures include all Medicare (Part A, Part B, and Part D) and Medicaid spending except Medicare or Medicaid spending on Part A, Part B, or Part D premiums. The Medicaid spending for partial-benefit dual eligibles is for coverage of Medicare cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC analysis of linked Medicare-Medicaid enrollment and spending data.

dual eligibles; Medicare accounted for about 57 percent of the combined spending and Medicaid the other 43 percent.

The high Medicare costs for dual eligibles are driven by a combination of higher utilization of all major types of services and higher per user spending for those who receive care. For example, in 2021, full-benefit dual eligibles were more likely than other Medicare beneficiaries to use inpatient care (22 percent vs. 13 percent), and those who were hospitalized had higher inpatient costs ($27,207 vs. $22,092, respectively). The Medicaid costs for full-benefit dual eligibles were largely for LTSS, such as nursing home care and home- and community-based waiver programs. Less than half of full-benefit dual eligibles (43 percent) used LTSS in 2021, but spending on those services accounted for about 75 percent of this population's total Medicaid costs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024).

The share of dual-eligible beneficiaries enrolled in MA has grown rapidly

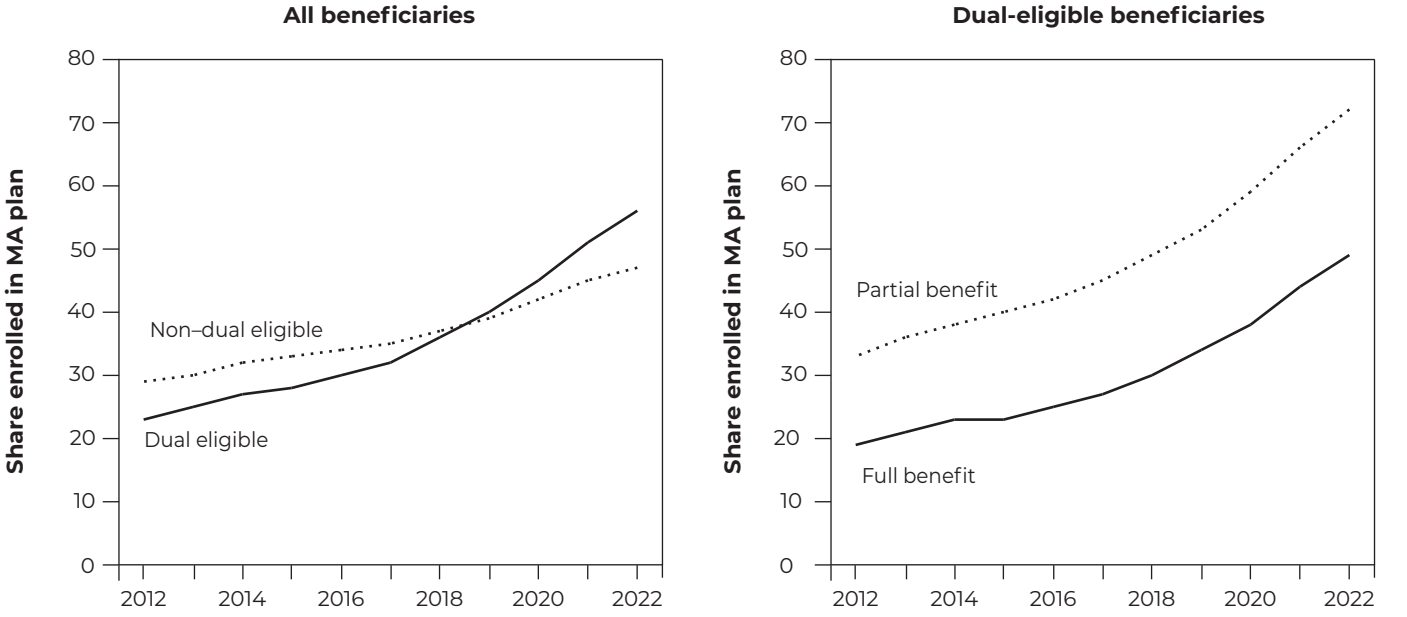
As with other beneficiaries, the share of dual eligibles enrolled in MA plans has grown rapidly in recent years. The left half of Figure 14-1 shows the share of dual-eligible and non-dual-eligible beneficiaries enrolled in MA from 2012 to 2022. Dual eligibles were historically less likely than other beneficiaries to enroll in managed care plans, but that pattern reversed during this period, and the share of dual eligibles enrolled in MA is now higher than that of non-dual-eligible beneficiaries (56 percent vs. 47 percent in 2022). Within the dual-eligible population, as shown on the right half of Figure 14-1, partial-benefit dual eligibles have consistently been more likely than full-benefit dual eligibles to enroll in MA plans. Between 2012 and 2022, the MA participation rates for both groups more than doubled, but the growth for partial-benefit dual eligibles was particularly rapid, and more than 70 percent are now enrolled in MA plans.

It is worth noting that Figure 14-1 does not include enrollment in plans that are not part of the MA program, such as cost plans, Medicare-Medicaid Plans (MMPs), and the Program of All-Inclusive Care for the Elderly (PACE). In 2022, about 6 percent of full-benefit dual eligibles were enrolled in those plans (largely in MMPs), compared with 1 percent of non-dual-eligible beneficiaries. Very few partial-benefit dual eligibles were enrolled in non-MA plans.

Dual-eligible beneficiaries also tend to enroll in different types of MA plans than other beneficiaries (Table 14-2, p. 472). In 2022, among beneficiaries

FIGURE 14–1

The share of dual-eligible beneficiaries enrolled in MA plans rose substantially between 2012 and 2022



Note: MA (Medicare Advantage). Figures are based on enrollment in July of each year. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly).

Source: MedPAC analysis of Medicare enrollment and eligibility data.

who were not dually eligible, 75 percent were in conventional plans, which are available to all beneficiaries who have Part A and Part B and live in a plan's service area, and another 23 percent were in employer-sponsored plans, which are available only to beneficiaries who worked for specific companies. In contrast, among dual eligibles, 62 percent were enrolled in D–SNPs, while 34 percent were in conventional plans and only 1 percent of dual eligibles were in employer plans.

Full-benefit dual eligibles were particularly likely to enroll in D–SNPs instead of conventional plans (71 percent vs. 25 percent), while partial-benefit dual eligibles were split about evenly between the two plan types. For partial-benefit dual eligibles, plan choice appears to depend heavily on the extent of their Medicaid coverage. About half of partial-benefit dual eligibles—those with income below the federal poverty level—receive assistance with both Medicare premiums and cost sharing. These beneficiaries were more likely to enroll in D–SNPs instead of conventional plans (71 percent vs. 28 percent, about the same as full-benefit dual eligibles), probably because they prefer the more generous supplemental benefits that D–SNPs typically offer. In contrast, the other partial-benefit dual eligibles—with income between 100 percent and 135 percent of the poverty level—receive assistance with the Part B premium only. These beneficiaries were more likely to enroll in conventional plans than D–SNPs (74 percent vs. 22 percent) and appeared to prefer the lower cost sharing and out-of-pocket limits that conventional plans typically offer.

TABLE 14–2 **Distribution of MA enrollment by dual-eligibility status and type of plan, 2022**

	Conventional plan	Employer plan	D–SNP	Other MA plan
All Medicare beneficiaries	66%	18%	14%	2%
Non-dual-eligible beneficiaries	75	23	<1	1
Dual-eligible beneficiaries	34	1	62	3
Type of dual-eligible beneficiary				
Full-benefit dual eligibles	25	1	71	3
Partial-benefit dual eligibles	51	1	47	2
Medicaid covers Part A/B cost sharing	28	<1	71	1
Medicaid does not cover Part A/B cost sharing	74	1	22	3

Note: MA (Medicare Advantage), D–SNP (dual-eligible special needs plan). Figures are based on July enrollment. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums, and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly). Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment and eligibility data.

Integration requirements for D–SNPs

D–SNPs are based on the rationale that dual-eligible beneficiaries will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than they would from a conventional MA plan. The extent to which D–SNPs must integrate the delivery of Medicare and Medicaid services has evolved over time. When D–SNPs were first authorized in 2003, they did not have to meet any specific requirements for integration. The Congress enacted the first requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Since 2010, MIPPA has required D–SNPs to have Medicaid contracts that meet certain minimum requirements, such as specifying the plan's service area, the Medicaid services the plan provides (if any), and the plan's responsibility to coordinate the delivery of Medicaid services for its enrollees.

Later, with the Affordable Care Act of 2010, the Congress added requirements for plans that wanted to qualify as a *fully integrated dual-eligible* SNP (FIDE–SNP). These plans must be offered by an entity that has a capitated Medicaid contract to provide both institutional and community-based LTSS, and they can receive higher Medicare payments if their enrollees have high levels of functional impairment.

The BBA of 2018 built on the MIPPA standards by requiring D–SNPs, starting in 2021, to meet one of three additional criteria for integration:

- The plan meets a minimum set of requirements, determined by the Secretary, to coordinate the delivery of LTSS, behavioral health, or both for plan enrollees. CMS specified through regulation that these plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of "high-risk" full-benefit dual eligibles, which is defined by the state. CMS refers to these plans as *coordination-only D–SNPs*; they have the lowest level of integration because they do not have to provide any Medicaid services (plan enrollees instead receive those services through a Medicaid fee-for-service (FFS) program or a separate Medicaid managed care plan).

- The plan qualifies as either (1) a *highly integrated dual-eligible SNP* (HIDE–SNP) by having a capitated Medicaid contract to provide LTSS, behavioral health, or both; or (2) a FIDE–SNP. HIDE–SNPs fall somewhere in the middle in terms of their integration with Medicaid: They are more integrated than coordination-only plans because they provide some Medicaid services, but less integrated than FIDE–SNPs because their Medicaid contracts may not be as extensive and they can use a wider variety of contracting arrangements with states. FIDE–SNPs have the highest level of integration because they provide a broad range of Medicaid services, including substantial LTSS coverage.
- The plan assumes "clinical and financial responsibility" for both Medicare and Medicaid benefits provided to its enrollees. CMS has defined these plans as HIDE–SNPs or FIDE–SNPs that have exclusively aligned enrollment, which means that enrollment in the D–SNP is limited to dual eligibles who receive their Medicare and Medicaid benefits from the same parent company. Based on a separate BBA of 2018 provision, these plans must have a unified process for handling appeals and grievances (instead of separate processes for Medicare-covered and Medicaid-covered services).[3] The use of exclusively aligned enrollment also allows plans to integrate other aspects of the enrollee experience, such as member materials.

In addition to the requirements for Medicaid integration, D–SNPs must complete annual health risk assessments for their enrollees, have an approved evidence-based model of care, and report certain additional quality measures. Otherwise, they are largely subject to the same rules as conventional MA plans. For example, they can require enrollees to receive care from in-network providers, employ utilization management tools like prior authorization, and offer supplemental benefits that traditional Medicare does not cover.

This year, D–SNPs are available in 45 states and the District of Columbia; the only states without them are Alaska, Illinois, New Hampshire, North Dakota, and Vermont. As shown in Table 14-3 (p. 474), enrollment in D–SNPs has surged in recent years, jumping from 3.3 million in 2021 to 5.2 million in 2023. More than half of those beneficiaries (57 percent) were in coordination-only D–SNPs, which have the lowest level of integration. Another 35 percent were enrolled in HIDE–SNPs, and 8 percent were enrolled in FIDE–SNPs. Those percentages have changed relatively little since the new integration standards took effect in 2021.

The D–SNP categories that we use in our mandated report differ from the coordination-only, HIDE–SNP, and FIDE–SNP categories because they also account for whether HIDE–SNPs and FIDE–SNPs have exclusively aligned enrollment. However, as shown in the bottom half of Table 14-3 (p. 474), the differences between the two methods for categorizing D–SNPs are relatively modest. Nearly all HIDE–SNP enrollees are in plans that do not have exclusively aligned enrollment, while about 80 percent of FIDE–SNP enrollees are in plans that do have exclusively aligned enrollment.[4]

Comparing the performance of D–SNPs and other plans that serve dual-eligible beneficiaries

The BBA of 2018 directs the Commission to periodically examine how D–SNPs "perform among each other" using Healthcare Effectiveness Data and Information Set® (HEDIS®) quality measures or other data sources, such as the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey or plan encounter data, as appropriate (see text box for the legislative language of the mandate, p. 475).[5] We are also required to consult with the Medicaid and CHIP Payment and Access Commission in preparing these reports.

To the extent feasible, these reports must compare five types of plans that serve dual-eligible beneficiaries:

- three types of D–SNPs (divided according to the BBA of 2018's integration criteria);
- MMPs, which are demonstration plans that CMS and certain states have been testing as part of an effort to develop new models of care for dual eligibles; and
- other MA plans (but looking only at the dual-eligible beneficiaries enrolled in those plans).

TABLE 14–3 **Most D–SNP enrollees have been in plans with a low level of integration, 2021–2023**

	Enrollment (thousands)			Share of D–SNP total		
Plan type	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
Coordination-only D–SNP	1,904	2,186	2,971	57%	53%	57%
HIDE–SNP	1,128	1,559	1,815	34	38	35
FIDE–SNP	282	351	417	8	9	8
Total, all D–SNPs	3,313	4,096	5,204	100	100	100
Plan groupings specified in BBA of 2018 mandate:						
Coordination-only D–SNP	1,904	2,186	2,971	57	53	57
HIDE–SNP or FIDE–SNP without exclusively aligned enrollment	1,150	1,578	1,886	35	39	36
HIDE–SNP or FIDE–SNP with exclusively aligned enrollment	260	332	347	8	8	7

Note: D–SNP (dual-eligible special needs plan), HIDE–SNP (highly integrated dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan), BBA (Bipartisan Budget Act). Figures are based on July enrollment for each year and do not include plans in the U.S. territories. The terms "with exclusively aligned enrollment" and "without exclusively aligned enrollment" indicate whether the plan does or does not require all enrollees to have aligned enrollment. Components may not sum to totals because of rounding.

Source: MedPAC analysis of CMS enrollment and D–SNP integration data.

Another logical group to include in this comparison would be dual-eligible beneficiaries who are enrolled in FFS Medicare, although the mandate does not call for this. However, the Commission has previously noted that efforts to compare FFS and MA performance are hindered by several data limitations (such as a lack of clinical data for FFS enrollees and discrepancies between plans' HEDIS data and encounter data) and the challenges of adjusting for differences between the FFS and MA populations (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019). Given these challenges, we determined in our March 2023 report to the Congress that rigorous comparisons of quality and outcomes between MA and FFS could not be made (Medicare Payment Advisory Commission 2023).

In July 2022, about 42 percent of all dual eligibles were enrolled in Medicare's FFS program, 33 percent were enrolled in a D–SNP, 20 percent were enrolled in some other type of MA plan, and 3 percent were enrolled in an MMP.

Dual-eligible beneficiaries also account for a disproportionate share of the enrollment in two other, smaller plan types that target beneficiaries who need LTSS: MA institutional special needs plans and the Program of All-Inclusive Care for the Elderly (see text box on Medicare plans that target beneficiaries who need LTSS, p. 476).

HEDIS clinical quality measures

For this report, we analyzed person-level HEDIS data for measurement year 2021, the most recent year of available data at the time we performed our analysis. HEDIS is a set of quality measures that has been developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans. CMS requires both MA plans and MMPs to collect and report data annually for a subset of HEDIS measures. We also used HEDIS data in our first mandated report.

Legislative language for mandated report

Section 50311(b)(1)(E) of the Bipartisan Budget Act of 2018 reads:

(E) STUDY AND REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(e)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i). ■

The person-level HEDIS data have both beneficiary and plan identifiers, which we used to identify beneficiaries enrolled in D–SNPs, MMPs, and other MA plans and to determine which beneficiaries in other MA plans were dual-eligible beneficiaries. We divided the D–SNP enrollees into three groups based on the BBA integration criteria that each plan met in 2021.

CMS typically requires plan sponsors to collect and report HEDIS data at the contract level, but the BBA of 2018 mandate directs the Commission to use data reported at the plan level. The distinction between contract-level and plan-level data is important for certain measures. Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some "hybrid" measures for which sponsors can or must use both administrative data and data collected from a sample of enrollee medical records. When sponsors rely entirely

Medicare plans that target beneficiaries who need long-term services and supports primarily serve dual-eligible beneficiaries

Four of the plan types that we are directed to compare by the mandate in the Bipartisan Budget Act of 2018—the three types of dual-eligible special needs plans and Medicare-Medicaid Plans—are specifically designed to serve dual eligibles. However, two other plan types—MA institutional special needs plans (I–SNPs) and the Program of All-Inclusive Care for the Elderly (PACE)—also deserve mention because they target beneficiaries who need long-term services and supports (LTSS). Since Medicaid is the largest payer for LTSS, dual eligibles represent a disproportionate share of the enrollment in both types of plans.

I–SNPs are specialized MA plans for beneficiaries who need the level of care provided in a nursing home. These plans have the option of serving beneficiaries who already live in nursing homes, beneficiaries who are frail but still live in the community, or both. Most I–SNPs appear to focus on beneficiaries in nursing homes, although there is relatively little data available. I–SNPs are available only to beneficiaries who live in certain nursing homes in the plan's service area and typically rely on nurse practitioners to make regular visits to those facilities to deliver care on-site and avoid inpatient stays. In 2023, about 110,000 beneficiaries were enrolled in I–SNPs, and full-benefit dual eligibles have historically accounted for about 90 percent of I–SNP enrollees.

PACE plans serve beneficiaries who are age 55 or older and need the level of care provided in a nursing home. The program aims to keep people living in the community instead of going into nursing homes, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. PACE is the oldest type of integrated plan; it started as a demonstration in the early 1980s and was permanently authorized in 1997. In 2023, about 60,000 beneficiaries were enrolled in PACE plans, and full-benefit dual eligibles have usually accounted for almost all of their enrollment. ■

on administrative data for a measure, they report HEDIS data for every enrollee under a given contract, which makes it feasible to calculate scores for either the entire contract or any individual plan offered under that contract.

In contrast, when sponsors report data for hybrid measures, they collect data for a random sample of 411 enrollees, which is chosen at the contract level. (These sampling requirements are specified by the NCQA.) Since most contracts have multiple plans and may have both D–SNPs and other types of MA plans, this sample is too small to generate reliable plan-level estimates. CMS requires MA plan sponsors to report plan-level data for a subset of HEDIS measures for all types of special needs plans, including D–SNPs. That subset includes some hybrid measures, but sponsors are not required to collect any additional data for them, so the plan-level scores for them are not reliable. As a result, our analysis excludes four hybrid measures—colorectal cancer screening, controlling high blood pressure, comprehensive diabetes care, and transitions of care. CMS may want to consider requiring plan sponsors that collect data from medical records to use large enough samples (411 enrollees at the plan level, instead of at the contract level) to generate reliable estimates for SNPs. Such a change would help provide more meaningful information to dual-eligible beneficiaries when evaluating the D–SNPs offered in their area.

For each comparison group, we calculated scores for 23 HEDIS measures that had a total of 45 associated rates (Table 14-4, pp. 478–479). Some measures have more than one associated rate: For example, the

measure on follow-up after an emergency department visit for substance abuse has two rates, one for 7-day follow-up and one for 30-day follow-up. The number of observations that were used to calculate each rate varied depending on the enrollment in each plan type and the demographic and clinical specifications for each measure.

The results from our analysis are mixed—each plan type performed relatively well on some measures and relatively poorly on others—and do not clearly favor one plan type. (These findings are consistent with our first mandated report.) In many cases, the differences between the scores on a given measure are relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. CMS has addressed this challenge in some analyses by requiring scores to differ by at least 3 percentage points to have "practical significance" (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2023c).

We applied the concept of practical significance to our analysis by looking for cases where the highest or lowest score on a measure differed from every other score by at least 3 percentage points. Our goal was to identify instances in which one plan type clearly performed better or worse than the others. Using this approach, we found the following:

- Coordination-only D–SNPs did not perform noticeably better or worse on any rates.
- HIDE–SNPs and FIDE–SNPs without exclusively aligned enrollment performed better on three rates (both rates for kidney health evaluation for patients with diabetes and osteoporosis management in women who had a fracture) and worse on three rates (one of the rates for potentially harmful drug-disease interactions in older adults, initiation of substance use disorder treatment, and nonrecommended prostate screening in older men).
- HIDE–SNPs and FIDE–SNPs with exclusively aligned enrollment performed better on four rates (two rates for follow-up after emergency department visit for mental illness, adherence to antipsychotic medications for individuals with schizophrenia, adherence to statin therapy for patients with diabetes) and did not perform noticeably worse on any measure.
- MMPs had the greatest variation in performance in the five comparison groups. They performed better on three rates (one of the rates for potentially harmful drug-disease interactions in older adults and two rates for follow-up after hospitalization for mental illness), but they performed noticeably worse on six rates (both rates for adults' access to preventive/ambulatory health services, breast cancer screening, osteoporosis management in women who had a fracture, osteoporosis screening in older women, and use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease).
- Other MA plans did not perform noticeably better on any measure and performed worse on two behavioral health rates (follow-up after hospitalization for mental illness and follow-up after emergency department visit for mental illness).

Drawing broader conclusions about plan performance from this analysis is challenging because other factors may contribute to the variation in scores. For example, in 2021, 99 percent of beneficiaries lived in counties where at least one MA plan was available and 92 percent lived in counties where at least one D–SNP was available, but some plan types were not widely available. The more highly integrated plans, in particular, had limited availability: MMPs and FIDE–SNPs were available in only 9 and 12 states, respectively, and about 85 percent of the enrollment in each plan type was in just 5 states. Thus, differences in HEDIS scores across the five comparison groups could be influenced by factors such as regional differences in state Medicaid eligibility requirements, disease prevalence, access to care, and physician practice patterns.[6]

Another factor could be structural differences between MMPs and MA plans. MMPs are part of a demonstration and operate outside of the MA program. The two plan types differ in many ways, and differences in their enrollment models and quality incentives could affect their relative performance on HEDIS measures. In MA, almost all beneficiaries enroll voluntarily, while in MMPs, many beneficiaries

TABLE 14–4

HEDIS® scores for measurement year 2021, by plan type

Measure	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Access/availability of care					
Adults' access to preventive/ambulatory health services					
Ages 20–64	96.0%	95.6%	95.0%	91.5%	95.4%
Ages 65+	96.6	96.3	97.4	90.5	95.8
Initiation and engagement of substance use disorder treatment					
Initiation	37.8	26.7	33.7	40.7	33.7
Engagement	7.0	4.3	6.1	7.6	5.0
Effectiveness of care: Behavioral health					
Antidepressant medication management					
Effective acute phase treatment	76.0	77.2	79.7	76.9	79.9
Effective continuation phase treatment	59.3	60.3	66.3	63.9	64.7
Follow-up after emergency department visit for substance abuse					
7-day follow-up	12.8	11.2	14.5	14.3	12.4
30-day follow-up	18.1	16.5	18.5	21.4	17.7
Follow-up after hospitalization for mental illness					
7-day follow-up, ages 18–64	28.0	32.1	31.7	41.8	26.3
7-day follow-up, ages 65+	22.1	24.4	32.3	30.1	20.0
30-day follow-up, ages 18–64	49.1	52.4	51.9	63.0	46.2
30-day follow-up, ages 65+	40.8	42.5	55.8	54.4	36.8
Follow-up after emergency department visit for mental illness					
7-day follow-up, ages 18–64	34.4	34.2	53.3	54.5	31.3
7-day follow-up, ages 65+	28.7	28.0	45.3	35.7	29.9
30-day follow-up, ages 18–64	51.8	52.1	66.5	68.7	47.4
30-day follow-up, ages 65+	42.8	42.0	57.8	49.6	42.4
Adherence to antipsychotic medications for individuals with schizophrenia	74.2	75.8	81.1	78.0	75.5
Effectiveness of care: Cardiovascular conditions					
Cardiac rehabilitation					
Attended 2+ sessions within 30 days	2.6	2.2	3.5	2.1	2.7
Attended 12+ sessions within 90 days	2.7	2.4	3.0	3.1	3.1
Attended 24+ sessions within 180 days	2.5	2.3	2.6	3.3	2.8
Attended 36+ sessions within 180 days	1.1	1.2	0.7	2.2	1.3
Persistence of beta-blocker treatment after a heart attack	89.3	89.0	87.9	91.1	87.6
Statin therapy for patients with cardiovascular disease					
Received statin therapy	85.1	85.5	87.0	83.8	85.5
Statin adherence 80%	82.1	83.3	85.7	84.3	82.9

TABLE 14–4

HEDIS® scores for measurement year 2021, by plan type *(cont.)*

Measure	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Effectiveness of care: Diabetes					
Kidney health evaluation for patients with diabetes					
Ages 18–64	36.9	47.2	35.9	38.6	40.6
Ages 65–85	45.8	56.4	46.5	47.6	50.6
Statin therapy for patients with diabetes					
Received statin therapy	79.8	81.2	83.3	78.4	80.4
Statin adherence 80%	81.2	81.8	85.3	82.3	81.6
Effectiveness of care: Care coordination					
Follow-up after emergency department visit for people with multiple high-risk chronic conditions					
Ages 18–64	56.4	57.5	60.6	60.7	57.0
Ages 65+	57.1	58.3	59.3	54.6	56.2
Effectiveness of care: Musculoskeletal conditions					
Osteoporosis screening in older women	45.6	49.1	46.1	34.9	48.5
Osteoporosis management in women who had a fracture	42.6	47.8	38.5	22.2	42.4
Effectiveness of care: Overuse/appropriateness (lower scores indicate better performance)					
Use of high-risk medications in older adults	22.4	22.7	23.6	17.7	20.6
Potentially harmful drug-disease interactions in older adults					
History of falls	41.5	40.5	40.4	35.7	39.8
Dementia	43.3	46.3	42.4	40.4	41.7
Chronic kidney disease	12.6	14.7	12.2	13.2	10.3
Use of opioids at high dosage	5.8	8.4	7.5	7.5	6.4
Nonrecommended PSA-based screening in older men	28.6	33.2	25.4	25.2	28.2
Use of opioids from multiple providers					
Multiple pharmacies	2.0	1.7	1.4	2.2	1.6
Multiple prescribers	15.6	13.2	15.1	16.0	13.8
Multiple prescribers and pharmacies	1.0	0.9	0.8	1.4	0.8
Effectiveness of care: Prevention and screening					
Breast cancer screening	69.6	71.3	67.8	58.5	68.3
Effectiveness of care: Respiratory conditions					
Pharmacotherapy management of COPD exacerbation					
Systemic corticosteroid	74.0	72.7	72.2	73.6	73.5
Bronchodilator	86.3	86.7	89.3	88.3	85.5
Use of spirometry testing in the assessment and diagnosis of COPD	26.8	26.3	26.3	20.0	23.9

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), D–SNP (dual-eligible special needs plan), HIDE–SNP (highly integrated dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage), PSA (prostate-specific antigen), COPD (chronic obstructive pulmonary disease). Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2021 and D–SNP integration data for 2021.

have been passively enrolled by states. MMPs might have more difficulty engaging with passive enrollees, which could contribute to their poor performance on some measures. Both types of plans have quality incentives, but the incentive for MA plans is structured as a bonus (higher payments for plans with a rating of 4 stars or better), while the incentive for MMPs is structured as a quality withhold (lower payments for plans that do not meet performance thresholds), and they are not evaluated on the same HEDIS measures. Three measures in Table 14-4 (pp. 478–479) (breast cancer screening, osteoporosis management in women who had a fracture, and statin therapy for patients with cardiovascular disease) are used in the MA star ratings but not the MMP quality withhold, and MA plans performed better than MMPs on three of the four rates associated with those measures, particularly breast cancer screening and osteoporosis management. Conversely, one measure (follow-up after hospitalization for mental illness) is used in the MMP quality withhold but not the MA star ratings, and MMPs generally performed better than MA plans on the four rates associated with that measure, particularly the rates for beneficiaries under age 65. Some of the differences in HEDIS scores may thus reflect differences in plans' financial incentives to focus on certain measures over others.

The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). Most HEDIS measures are process measures that are not tied to clinical outcomes, but the Commission holds that measures tied to clinical outcomes and patient experience are more suitable for quality payment programs (Medicare Payment Advisory Commission 2018). CMS includes some process measures in the calculation of the MA star ratings, accounting for about 15 percent of a plan's overall star rating for 2024, but it gives more weight to outcomes and patient experience measures (Centers for Medicare & Medicaid Services 2023d).

In 2020, the Commission recommended replacing the MA quality bonus program with a new MA value incentive program that uses a small set of measures tied to clinical outcomes and patient experience to evaluate plan performance (Medicare Payment Advisory Commission 2020).

CAHPS patient experience measures

For this report, we also analyzed results from the CAHPS beneficiary survey, which was developed by the Agency for Healthcare Research and Quality (AHRQ) to assess patient experience with the health care system. This analysis is new and did not appear in our first mandated report.

Each year CMS requires MA plans and MMPs to administer a version of the survey to a sample of enrollees. The agency selects the sample and requires plans to hire an approved outside vendor to conduct the surveys. The surveys are usually conducted in the spring of each year and ask enrollees about their experience during the previous six months. For this report, we analyzed results from the surveys conducted in 2022, the most recent available. The responses to the survey thus refer to care that enrollees received in late 2021 and early 2022. Across all MA plans, about 35 percent of the enrollees who were selected for the 2022 survey responded (Centers for Medicare & Medicaid Services 2023a).

The MA version of the CAHPS survey has more than 60 questions, which makes it impractical to report the results for each question. We instead focused on scores for six composite measures, which combine the scores on groups of closely related individual measures, and on scores for five measures for which enrollees give an overall rating (from 0 to 10) of a key feature of their health care experience. For example, the composite measure for "how well doctors communicate" is based on four individual questions that ask if the enrollee's personal doctor explained things in a way that was easy to understand, listened carefully to the enrollee, showed respect for what the enrollee had to say, and spent enough time with the enrollee. We also present scores for one individual measure—the share of enrollees who received a flu shot—that is part of both the MA and MMP quality incentives. Our focus on a limited number of measures is consistent with AHRQ guidance and similar to the approach CMS uses to incorporate CAHPS scores in the MA star ratings (Agency for Healthcare Research and Quality 2015, Centers for Medicare & Medicaid Services 2022).[7]

We used beneficiary and plan identifiers, as we did with the HEDIS data, to determine which CAHPS respondents were dual-eligible beneficiaries and to

TABLE 14–5

CAHPS® scores from 2022 surveys, by plan type

	Overall average for all plan types	HIDE–SNPs and FIDE–SNPs			
		Coordination-only D–SNPs	Unaligned	Aligned	MMPs	Other MA plans
Composite measures						
Getting care quickly	74	76 (+)	73 (–)	74	74	75
Getting needed care	78	80 (+)	78	78	77 (–)	79
How well doctors communicate	89	90 (+)	89	90	89 (–)	89
Customer service	83	84 (+)	83	83	83	82
Care coordination	84	86 (+)	84	84	83	84
Getting needed prescription drugs	90	91 (+)	90	90	89 (–)	90
Enrollee ratings						
All health care	84	85	85	84	83 (–)	84
Personal doctor	91	91	90	91	89 (–)	91
Specialist	88	89	88	89	88	88
Health plan	89	91 (+)	90 (+)	89	87 (–)	87 (–)
Drug plan	90	91 (+)	91 (+)	91	89 (–)	89 (–)
Individual measure						
Received annual flu shot	68	65 (–)	66 (–)	73 (+)	69	70

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), D–SNP (dual-eligible special needs plan), HIDE–SNP (highly integrated dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage). All scores have been converted to a 0 to 100 scale (from low to high) for ease of interpretation and, except for the flu shot measure, have been case-mix adjusted for response bias. Figures do not include plans in the U.S. territories.
(+) Score is better than overall average and difference is statistically significant ($p < 0.05$).
(–) Score is worse than overall average and difference is statistically significant ($p < 0.05$).

Source: MedPAC analysis of CAHPS person-level data and D–SNP integration data for 2022.

assign them to the five comparison groups specified in the BBA mandate. We divided the D–SNP enrollees based on the integration criteria that each plan met in 2022. We also adjusted survey responses to account for differences in case mix, using the same factors that CMS applies when it adjusts CAHPS responses to calculate the MA star ratings. Finally, we converted the scores on each measure to a scale of 0 to 100 (from low to high) for ease of interpretation.

The CAHPS scores for each comparison group are shown in Table 14-5. Instances in which the difference between the score for a given plan type and the average score for all plan types were statistically significant using a t-test are marked with a plus sign (+) when the plan type performed better and a minus sign (–) when the plan type performed worse.[8] We found that the coordination-only D–SNPs, as a group, had higher scores on many measures, including all of the composite measures, and that the MMPs tended to have lower scores on many measures. This finding is somewhat counterintuitive since the level of integration is relatively low in coordination-only D–SNPs and high in MMPs. As with the HEDIS measures, structural differences between MA plans and MMPs may contribute to the somewhat lower scores for MMPs on CAHPS measures.

However, the differences between the highest- and lowest-performing plan types are relatively small in

absolute terms—only a few percentage points for most measures—and may not be very meaningful for beneficiaries. CMS has used a difference of 3 percentage points, as it has with HEDIS scores, as a threshold for "practical significance" in some analyses (Centers for Medicare & Medicaid Services 2023c). Using this threshold, the only measures with meaningful differences in scores were the overall health plan rating (for which coordination-only D–SNPs performed better than MMPs and other MA plans) and the share of enrollees who received a flu shot (for which FIDE–SNPs and HIDE–SNPs with exclusively aligned enrollment performed better than the other plan types).

Other analyses have also found that CAHPS scores for many measures tend to cluster within a narrow range. For example, the Commission identified clustering as one weakness of the MA star rating system and noted that the minimal differences in scores may not provide a reasonable basis for deciding which plans should receive a quality bonus (Medicare Payment Advisory Commission 2019). Similarly, a study that used CAHPS data from 2015 to 2019 found relatively small differences in the scores for dual-eligible beneficiaries enrolled in D–SNPs versus other MA plans (Haviland et al. 2021). Most recently, a study that used CAHPS data from 2015 to 2018 to compare the experience of dual-eligible beneficiaries in FIDE–SNPs, other D–SNPs, and other MA plans found relatively small differences in the scores for those plan groupings (Meyers et al. 2023).

The lower scores for MMPs, as with the HEDIS scores, may also be partly due to differences in the MA and MMP quality incentives. The MA star ratings use 9 of the 12 measures shown in Table 14-5 (p. 481), while the MMP quality withhold uses only 1 measure. On the only measure used in both systems, the flu shot measure, MMP performance was in the middle compared with the other plan types.

Most MMPs will likely convert into D–SNPs

MMPs are part of a broader effort known as the financial alignment demonstration in which CMS and states have tested new models of care for dual-eligible beneficiaries. Participating states have tested one of three models: (1) a capitated model that uses managed care plans (the MMPs) to provide both Medicare and Medicaid services, (2) a managed FFS model that provides greater care coordination to dual eligibles who are enrolled in both FFS Medicare and FFS Medicaid, and (3) an alternate model that tested new ways to integrate Medicare and Medicaid administrative functions within D–SNPs. CMS is conducting the demonstration using the authority of its Center for Medicare & Medicaid Innovation.

Most participating states (10 of 13) have tested the capitated model. There have been a total of 11 separate demonstrations using MMPs (New York had 2 demonstrations) that started between 2013 and 2016. The MMPs are distinctive because they provide all Medicare-covered and all or most Medicaid-covered services to their enrollees and are more highly integrated than even FIDE–SNPs. The MMPs are also noteworthy because states are allowed to passively enroll beneficiaries (who can opt out if they wish) and plans are paid using a blended Medicare-Medicaid payment rate that is reduced to reflect expected savings. We examined the financial alignment demonstration in depth in our June 2018 and June 2016 reports (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2016).

At their peak, MMPs had between 400,000 and 450,000 enrollees, making the demonstration one of the largest specifically aimed at dual-eligible beneficiaries. Eight of the 11 demonstrations (in Illinois, Massachusetts, Michigan, New York (1 of 2 demonstrations in New York), Ohio, Rhode Island, South Carolina, and Texas) are still in operation, while 3 (in California, New York (the other of 2 demonstrations in New York), and Virginia) have ended. About 300,000 beneficiaries are currently enrolled in MMPs, with the majority in Illinois and Ohio.

CMS has contracted with RTI International (RTI) to evaluate the effects of each demonstration on areas such as program costs and service use. The evaluations that have been released so far typically cover the first four to five years of a demonstration (Feng and Greene 2023a, Feng and Greene 2023b, Feng and Greene 2023c, Feng and Greene 2023d, Feng and Greene 2023e, Feng and Greene 2023f, Feng and Greene 2023g, Feng and Greene 2022a, Feng and Greene 2022b, Feng

and Greene 2021a, Feng and Greene 2021b). Those evaluations have found:

- *Higher Medicare spending.* Eight MMP demonstrations have resulted in statistically significant increases in Medicare spending, with estimates ranging from 3.1 percent to 9.8 percent. These estimates were based on a comparison of Medicare spending under the demonstration and an estimate of what Medicare would have spent without the demonstration. Two MMP demonstrations also led to higher spending, but the differences were not statistically significant; RTI did not estimate the effects of one MMP demonstration due to data limitations.
- *Challenges in estimating effects on Medicaid spending.* RTI has not been able to estimate the Medicaid spending effects of 7 of the 11 MMP demonstrations due to a variety of data limitations. Among the four MMP demonstrations where RTI was able to calculate an estimate, two demonstrations have seen statistically significant increases in Medicaid spending, ranging from 6.6 percent to 32.0 percent. These estimates were based on a comparison of Medicaid spending under the demonstration and an estimate of what Medicaid would have spent without the demonstration. The other two demonstrations had effects on Medicaid spending (higher in one case and lower in the other) that were not statistically significant.
- *Mixed effects on service use.* One key question about the MMP demonstrations had been whether MMPs could achieve more desirable patterns of service use—for example, reducing the use of inpatient hospital services, emergency rooms, and nursing homes, and expanding the use of primary care, ambulatory care, and home- and community-based forms of LTSS. RTI produced estimates for 7 of the 11 MMP demonstrations. It found that the use of physician evaluation and management services had increased in four demonstrations, with statistically insignificant changes in the other three demonstrations. RTI also found that beneficiaries in three demonstrations were more likely to have an emergency room visit, with statistically insignificant changes in the other four demonstrations. However, the effects on other services—such as inpatient admissions and long nursing home stays—were mixed, with increases in some demonstrations and decreases in others.

The findings from the evaluations are somewhat challenging to interpret given the analytic approach that was used. RTI measured the effects of the demonstrations by comparing dual-eligible beneficiaries who are eligible for the demonstrations (whether or not they actually participate) with similar groups of dual eligibles in other states. The participation rates for many demonstrations have been lower than expected, often between 20 percent and 40 percent, making it less clear that any differences between the demonstration-eligible and comparison populations are due to the demonstration rather than other factors. However, higher Medicare spending has been a reasonably consistent finding, even in demonstrations with relatively high participation rates. The evaluations also do not explain exactly *why* the demonstrations have increased spending.

CMS has announced that it plans to end the MMP demonstrations in 2025. When that happens, we expect most MMPs to convert into D–SNPs. In most cases, these successor plans will likely have some meaningful level of integration with Medicaid and qualify as either HIDE–SNPs or FIDE–SNPs. At that point, unless policymakers develop an entirely new plan type, any future efforts to improve Medicare–Medicaid integration will likely use the D–SNP model as a starting point.

Conclusion

Dual-eligible beneficiaries tend to be in poorer health than other Medicare beneficiaries and may face challenges obtaining care from two separate programs. Managed care plans that provide both Medicare and Medicaid services, such as D–SNPs, have the potential to improve care for this population, but their level of integration with Medicaid varies. Unfortunately, HEDIS and CAHPS quality data provide limited insight into the relative performance of D–SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. These challenges are not

unique to D–SNPs and reflect larger difficulties in assessing the quality and performance of MA plans. For our next mandated report, we plan to add ambulatory care–sensitive hospitalization rates (calculated using a combination of MA encounter data and hospital discharge data) to provide another way of assessing plan performance. ■

Endnotes

1 When dual eligibles receive assistance with Medicare cost sharing, Medicaid law lets states limit their payment to the lesser of the Medicare cost-sharing amount or the difference, if any, between the Medicare and Medicaid payment rates for the service. Most states have these "lesser of" policies; since Medicaid rates are typically lower than Medicare rates, states may pay only a portion of the cost sharing or none at all. When states do not pay the entire cost-sharing amount, providers cannot bill beneficiaries for the difference.

2 ADLs include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.

3 CMS also requires coordination-only D-SNPs to have a unified process for handling appeals and grievances if they have exclusively aligned enrollment and provide a minimum set of Medicaid-covered services. The various types of D-SNPs that are required to have a unified process for handling appeals and grievances are collectively referred to as applicable integrated plans.

4 Starting in 2025, CMS will require FIDE–SNPs to use exclusively aligned enrollment. Among FIDE–SNPs that do not currently use exclusively aligned enrollment, some plans may modify their enrollment rules to comply with the new requirement (thus keeping their FIDE–SNP status), while some plans may decide instead to become HIDE–SNPs, which are not required to use exclusively aligned enrollment.

5 HEDIS® is a registered trademark of the National Committee for Quality Assurance; CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

6 One type of variation that we investigated was the share of enrollees who qualify for full or partial Medicaid benefits. In 2021, partial-benefit dual eligibles accounted for 53 percent of the dual eligibles enrolled in other MA plans and 30 percent of HIDE–SNP and coordination-only D–SNP enrollees, but less than 1 percent of FIDE–SNP and MMP enrollees. When we calculated HEDIS scores using data for full-benefit dual eligibles only, the effects on our findings were relatively modest.

7 As part of the MA star ratings, CMS uses five of the six composite measures, three of the five measures in which enrollees rate their health care experience, and the flu shot measure.

8 We measured statistical significance by comparing the score for each plan type with the unweighted average of the scores for all plan types. As a sensitivity test, we also measured statistical significance using the enrollment-weighted average of the scores for all plan types. Using this alternate method had very little effect on our findings.

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